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Managing Patients with Lower Gastrointestinal Bleeding

Dr. Buch:

Welcome to *GI insights* on ReachMD. I'm your host, Dr. Peter Buch. And today we're joined by Dr. Neil Sengupta, who is an Associate Professor c Medicine at the University of Chicago and a lead author of the article, titled "Management of Patients With Acute Lower Gastrointestinal Bleeding: Aı Updated ACG Guideline," which was published in *The American Journal of Gastroenterology* in 2023.

Dr. Sengupta, welcome to the program.

Dr. Sengupta:

Thank you, Dr. Buch. It's a pleasure.

Dr. Buch:

We're looking to learn from you. Let's dive right in, Dr. Sengupta. Can you give us an overview of the updated guidelines from the American College c Gastroenterology?

Dr. Sengupta:

Certainly. So the prior iteration of this guideline was published in 2015, and since that time there have been numerous updates to the field of lowe gastrointestinal bleeding, and those updates include diagnostic strategies of managing patients with lower gastrointestinal bleeding, the use of ris assessment tools, the role of reversal agents for patients on anticoagulation, timing of colonoscopy, and because of that, we felt it was important t provide a timely update where we can provide clinicians with the latest evidence-based recommendations for the management of this very commo condition. So what we did was we used the GRADE framework to develop several evidence-based recommendations spanning the management of lowe gastrointestinal bleeding, and that includes the use of risk stratification tools, the role of reversal agents for patients on anticoagulants, appropriat diagnostic tests, such as CT angiography, and appropriate timing of colonoscopy; and then finally, we talk a little bit about strategies to reduce the risk c recurrent bleeding.

Dr. Buch:

Perfect. And with that in mind, which patients with acute lower GI bleeding on vitamin K antagonists should receive therapy? And what therapy i recommended?

Dr. Sengupta:

Certainly. So the use of anticoagulants is increasingly common in the population of patients presenting with lower gastrointestinal bleeding. For the mos part, most patients presenting with bleeding likely do not require reversal as most patients do well with intravascular volume resuscitation and conservativ management alone. However, there may be a subset of patients on vitamin K antagonists who present with severe bleeding, they may b hemodynamically unstable, and they may have a prolonged INR over three. And so in the setting of patients who have severe life-threatening bleedin despite intravenous resuscitation and their INR is prolonged, those are candidates for reversal. The ideal strategies for patients on vitamin K antagonist

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include prothrombin complex concentrate or 4-factor PCC, which is generally preferred to fresh frozen plasma because it works quicker to reverse th INR. General vitamin K is not really recommended because it takes a long time to work, and it hasn't really been shown to be effective in studies. S that's how we typically approach the management of patients on vitamin K antagonists.

Dr. Buch:

And the other factor with regard to vitamin K antagonists, those patients who need to be going back on the anticoagulants, what would happen wit reversing that process with vitamin K antagonists?

Dr. Sengupta:

Certainly. So after reversal, we typically perform endoscopy to localize the source of bleeding and treat it. An important part of management afte hemostasis is achieved is actually resuming their anticoagulant. In the past, we've seen many patients who have their anticoagulants held after hospitalization for GI bleeding, and that puts that patient at risk for adverse outcomes, such as stroke or mortality. So there have been several studie showing that resumption of anticoagulation early, ideally within a week or two, has been shown to be associated with protection from mortality and strok compared to holding their anticoagulant, so because of that, clinicians should make every effort possible to resume their anticoagulant, be it vitamin antagonist or be it a direct oral anticoagulant because that has shown to be protective from future strokes or future thromboembolic complications.

Dr. Buch:

And as a further follow-up to that for our primary care listeners out there, can you explain to them how we weigh bleeding versus thrombotic events an how that's changed in these last few years?

Dr. Sengupta:

Great question. Well traditionally, there was this fear of bleeding, and so as I was referring to earlier, anticoagulants can often be held due to a history o bleeding, but for the vast majority of patients who present with gastrointestinal bleeding, it can usually be managed either conservatively c endoscopically, and so the challenge is we want to avoid catastrophic thrombotic complications that can occur, such as a heart attack or stroke. And w always say that the heart is more important than the gut. The gut can be managed, typically speaking with endoscopic interventions, and so because c that, in general, the balance I think should tip in favor of resumption of anticoagulation versus the concerns about risks of rebleeding.

Dr. Buch:

And should a patient who has a lower GI bleed and is taking aspirin be maintained on aspirin during hospitalization?

Dr. Sengupta:

I would say the vast majority of patients who are on aspirin for secondary cardiovascular protection should be continued on aspirin while they present t the hospital with lower GI bleeding. By secondary cardiovascular prevention, I mean patients who have had an established history of cardiovascula disease. And those patients, they likely benefit from continuing their aspirin as opposed to holding their aspirin, because holding their aspirin may pu them at risk for future cardiovascular complications. For patients who are on aspirin for primary prophylaxis who have not had a prior episode of coronar artery disease, those patients likely can discontinue their aspirin when they present to the hospital.

Dr. Buch:

So, Dr. Sengupta, can you tell us about the safety of endoscopic procedures while a patient is still on antiplatelet medication?

Dr. Sengupta:

In general, endoscopic procedures are perfectly safe on antiplatelets and anticoagulants. For anticoagulants, we can perform therapeutic endoscopi procedures for patients on therapeutic anticoagulation, and we can also do the same for patients on aspirin and non-aspirin antiplatelets. Typicall speaking, the forms of endoscopic intervention can include clips, cautery, or epinephrine injection, and all of those can be done while on antiplatelets, s

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that should not be a deterrent to perform endoscopic intervention.

Dr. Buch:
For those just tuning in, you're listening to *GI Insights* on ReachMD. I'm Dr. Peter Buch, and I'm speaking with Dr. Neil Sengupta about the updated ACG guidelines for patients with lower GI bleeding.

Now, Dr. Sengupta, which GI patients would benefit most from a CT angiogram?

Dr. Sengupta:
This is an area where we have provided updated recommendations compared to the prior iteration of the ACG guidelines in 2015. There is increasin data that patients who have severe hematochezia with active bleeding benefit from a CT angiogram because it's been shown to be highly sensitive an specific in terms of detecting the location of bleeding. So we recommend that for patients who have severe hematochezia with active bleeding, thos patients probably benefit from a CT angiogram as their initial diagnostic study as opposed to a rapid colonoscopy because those patients may not be abl to tolerate a bowel preparation. And oftentimes, performing a colonoscopy is challenging with these patients because when we perform a colonoscop we may only see blood in the colon. So for those patients who have active bleeding and whom they have had a recent episode of hematochezia within, I' say four to six hours of presentation, those patients likely benefit from an immediate CT angiogram.

The CT angiogram is noninvasive, it's done without oral contrast, and it can rapidly detect the etiology and location of bleeding. And those patients wh have a CT angiogram, which shows extravasation of contrast into the gut, they can then be triaged to interventional radiology where they can undergo a angiogram with embolization of bleeding. Another option is for patients who have positive CTA with extravasation, those patients may also benefit fro performing a timely colonoscopy to then perform a therapeutic intervention. So I do think there's an expanded role for CTA for patients with active lowe GI bleeding.

Now the converse of that is there is limited role for a CTA in those patients in whom bleeding has subsided. So let's say a patient has had some sma volume bleeding or they haven't had any bleeding in the last 12 hours. Those patients probably don't need a CTA, and they would benefit from going t colonoscopy.

Dr. Buch:
And what recommendations do you have about the timing of a colonoscopy after a patient has lower GI bleeding?

Dr. Sengupta:
Timing of colonoscopy has been a relatively controversial area in the last several years. However, in the last five years, we've had several randomize controlled trials that have compared the outcomes of patients undergoing urgent colonoscopy, which was defined as within 24 hours of presentation, to nonurgent or elective colonoscopy, which is defined as beyond 24 hours. The outcomes that have been studied were rebleeding, mortality, and then a fe other secondary outcomes. And in general, all of those randomized controlled trials have really shown that there doesn't appear to be any significa benefit for performing urgent colonoscopy within 24 hours. So because of that data, we recommend performing a colonoscopy whenever it's feasible i the hospital, so we say a nonurgent next-available colonoscopy after the patient's resuscitated and we make that recommendation because urge colonoscopy has not been shown to be associated with a reduction in rebleeding or mortality. So those patients who come in with bleeding who requi colonoscopy, they probably should just get it in the next day or two depending on various factors, such as the adequacy of bowel preparation, th availability of slots to perform a colonoscopy, etc.

Dr. Buch:
And before we conclude our discussion, Dr. Sengupta, are there any other thoughts you'd like to share with our audience today?

Dr. Sengupta:
Certainly. Lower GI bleeding is one of the most common reasons that patients are hospitalized due to a digestive disorder in this country. Despite that, have actually shockingly, little high-quality data that helps guide the management of this condition. There's very relatively few randomized controlled trial

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that have been published, so this is a topic area where we need more data to help guide our decision-making.

In general, I would say that oftentimes, we perform a lot of inpatient colonoscopies for patients with recurrent lower GI bleeding. However, oftentimes, those colonoscopies are relatively low value. We don't really perform a lot of therapeutic intervention in the United States when we do inpatient colonoscopy, so it's important to decide who benefits from a colonoscopy and who doesn't benefit from a colonoscopy. I think patients who benefit from a colonoscopy are those with ongoing bleeding in whom the probability of finding and treating the source is higher. And there's also, I think, a lot of value in performing a colonoscopy for patients in whom you're worried about cancer or a vascular lesion as a cause of bleeding. But for patients who have had recurrent diverticular bleeding, who have had several colonoscopies in the past that has excluded things like cancer or vascular lesions, those patients may not need an inpatient colonoscopy if their bleeding has subsided and may be followed conservatively.

Dr. Buch:

Excellent. This has been a wonderful review of lower GI bleeding. I want to thank my guest, Dr. Neil Sengupta, for sharing his insights.

Dr. Sengupta, it was a pleasure speaking with you today.

Dr. Sengupta:

Thank you for having me, Dr. Buch. I appreciate it.

Dr. Buch:

For ReachMD, I'm Dr. Peter Buch. To access this and other episodes in this series, visit ReachMD.com/GIInsights where you can Be Part of th Knowledge. Thanks for listening, and see you next time.

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